Anti Smoking Research Programme

An Exercise to Help Evaluate the Efficacy of Anti-Smoking Therapy Using Hypnotherapy - Bristol 2000 - 2003

Background
We are all aware of the general consensus of hypnotherapists that Anti-Smoking therapy is highly successful. Indeed, often practitioners will advertise their success rate. Some assess it to be as high as 90%, and there is no reason to believe that they doubt the veracity of the claim. Some even advertise "lifetime guarantee". Sadly, alarmingly, the success evidence is often of the variety that "none of my clients come back, therapy was obviously successful". That is not to say, of course, that anecdotal evidence is always wildly inaccurate. Closer inspection of the "lifetime guarantee" does not involve the repayment of any fees, but rather a commitment that customers who fail to become non-smokers first time around can come back for more.

I have always suspected that I have been as successful as any experienced hypnotherapist. I have been seeing about 250 people each year in Bristol for at least 8 years for anti-smoking therapy and the number of recommendations from previous clients seemed to confirm this. So, yes, I have long thought of myself as in the nine out of ten category.

Early in 2000 I decided I would set up a programme to endeavour to confirm or otherwise the success of anti-smoking therapy, particularly my version of it, to provide evidence that could at least be construed as more substantial than hearsay and anecdote. I say "at least" because research into hypnotherapy is by its very nature difficult because of the inherent placebo and nocebo factors. A straight forward system whereby the client reports at a certain stage or stages how well they are doing runs the risk of introducing a powerful negative factor. This could be very unfair to the customer. Some sort of compromise is inevitable to achieve a fair picture. Even so, the simple compromise programme I accepted infused a certain amount of negativity as I have reflected upon in my conclusion.

Method
From January 2000 it was clearly stated in my anti-smoking brochure that if anyone had difficulties during the first six months, and a 'top-up' was needed, then it would be done at no extra cost. Receptionists were briefed of this for when replying to telephone enquiries. Everyone was obliged to have a brochure sent to them prior to their appointment. I always then finished the clinical session with the words to the effect "I am always here if you need help".

Then we left it at that for a year or so to allow the market place to get used to the idea. There is no doubt that it permeated into the psyche and clients would often leave with the words "I hope I do not have to see you again" or something similar.

During 2001, 2002 and into 2003 we formally recorded data. I generally see between 30 and 40 clients each week. I necessarily have to restrict the number of anti-smoking sessions I conduct. There is always somewhat of a wastage too because of appointment delay, which at times was 2 to 3 months. In the event I saw 469 customers during the twenty-four months under scrutiny. This figure does not include another 70-80 patients I estimate would have given up smoking as part of their ongoing treatment for depression, anxiety etc. These are not part of the evaluation. There were also a further 62 people who had seen me or other hypnotherapists for giving up smoking during the last five years and needed to go through the procedure again..

An anti-smoking session for me is normally a one-off and lasts ninety minutes.

The Aim
To evaluate as far as possible how successful anti-smoking therapy was over a two-year period at the Clifton Practice. At the same time it seemed to be a good opportunity to provide data generally about people wanting to give up smoking. In particular I was interested in the relationship smoking, or more importantly the inability to give up tobacco, has with anxiety and depression.

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The Exercise Data 2001 - 2003

Where the Clients Came From

Client Recommendation	74 %
Yellow Pages	12 %
Practitioner/Doctor Referral	6 %
Internet	8 %

Comment: *These percentages reflect the fact that I am reasonably well established. Many more enquiries came from the Yellow Pages, the internet and the Hypnotherapy Societies, but these people were less inclined to wait for an appointment than someone who came via a recommendation.*

The Number of 'Top Ups' Required During the First Six Months and When

1 month	2 months	3 months	4 months	5 months	6 months	Total
14	9	4	4	4	4	39
2.9 %	1.9 %	0.85 %	0.85 %	0.85 %	0.85 %	8.3%

Comment: *On paper these figures look pretty encouraging. However, there would have been people who 'failed' and did not return for further treatment. I hope not many..*

Men/Women

Men	Women
43%	57%

Age Groups

-20	21 - 30	31 - 40	41 - 50	51 - 60	61 - 70	70+
2 %	30 %	40 %	16 %	9 %	2.5 %	0.5%

Average Number of Cigarettes Each Day

< 10	11 - 20	21 - 30	31 - 40	41 - 50	51 - 60	> 60
17 %	52 %	19 %	9 %	1.5 %	1.5 %	0.5 %

Symptoms That Could Be Associated With Anxiety/Depression

IBS	Headaches /Migraine	Anxiety/ Depression	Medication Anxiety/ Depression	Panic Attacks	Phobias/ Fear Response	Disordered Sleep
10 %	19 %	15 %	12 %	18 %	38 %	46 %

Notes

The following criteria were used in the fact finding: IBS: symptoms diagnosed by the client's GP. Headaches/Migraine: ongoing, regular and severe enough to be a problem Anxiety/Depression: symptoms diagnosed by client's GP. Medication Anxiety/Depression: prescription drugs. Panic Attacks: severe enough to consult GP during last five years. Disordered sleep: difficulty in sleeping, difficulty in remaining asleep or both. Phobias/Fear responses: severe enough to be a debilitating factor.

Comments

This exercise was not intended to be research as such. It was to provide some evidence to corroborate the general opinion that either smoking is the cause of symptoms or is a result of symptoms of anxiety or depression. Overall approx 65% exhibited symptoms that could be associated with Anxiety/Depression.

Conclusion

Everyone would be well able to draw their own conclusions from this exercise. On the basis of who had difficulties or who failed during the first six months, and after all this would be what anecdotal evidence is generally based on, then we could give ourselves nine out of ten, particularly as quite a large number returned for a 'top-up' because of sloppiness rather than any real difficulty. One wonders if they might have been quite so cavalier if a "free" second go had not been available. We might wonder also that if we extended the exercise to cover a sixty month period…

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